

# New Jersey Early Intervention System & Children with Autism Spectrum Disorders

Technical Guidance for the Provision of Services and Supports

October 2010

Replaces and supersedes previous editions

The Department of Health and Senior Services is the lead agency for the Early Intervention System in New Jersey. The following Department staff members were responsible for creating, reviewing and finalizing this technical assistance document.

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The New Jersey Department of Health and Senior Services (DHSS) is committed to providing quality services for eligible infants and toddlers with disabilities and their families through the New Jersey Early Intervention System (NJEIS) established within the Division of Family Health Services. These services are designed to be consistent with federal and state requirements and developmentally appropriate practice.

### Historical Background of these Guidelines

In 1999 the NJEIS convened and charged an autism task force with enhancing the system's capacity to provide access to appropriate services for the increasing number of children with Autism Spectrum Disorders (ASD) participating in the NJEIS. The Early Intervention Autism Task Force included representation from families and professionals throughout New Jersey. Major recommendations were presented to DHSS based on the collective work of the task force and an analysis of the National Research Council's 2001 report Educating Children with Autism<sup>1</sup>

The first guideline document was published in 2003 as a result of the task force and became the foundation for Early Intervention Provider Agencies and Service Coordination Units to improve their understanding of Individualized Family Service Plan (IFSP) development and implementation for young children with ASD.

Since the first autism service guidelines publication of the NJEIS, the capacities and capabilities of NJEIS provider agencies and individual practitioners have expanded and matured. DHSS continues to provide ongoing technical assistance to local and regional level staff and administration based on the rules, policies and procedures of the NJEIS and the on-going developments in both autism and early intervention research.

The recommendations of the 2003 NJEIS Autism Task Force and the National Research Council continue to be relevant to the provision of services to children and families and those recommendations are contained within.

**The guidance provided in this edition underwent stakeholder review prior to publication.**

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<sup>1</sup> National Research Council (2001) *Educating Children with Autism*. Committee on Educational Interventions for Children with Autism. Catherine Lord and James P. McGee, eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

There is consensus that “early intervention is essential” for children diagnosed with an ASD. But what is “early intervention”? What is meant by “early”, what “intervention” should be put in place and how do families of young children diagnosed with an ASD access “early intervention?”

For starters it is important to remember that “early intervention” is both a *concept* and a *system of service*.

### *The Concept of Early Intervention*

While all children grow and develop in unique ways, some children experience delays in their development. If a child experiences a developmental delay, the results of the delays can compound over time and it may become more difficult to modify established patterns of development. Taking action to minimize the effects of delays or diagnosed conditions at the earliest stages of development is the concept of “early intervention.” As young children with ASD struggle with language, social communication, play and appropriate behavior, they have multiple areas of development that will benefit from targeted interventions designed to lessen the effects of their delays. Characteristics of ASD are present before the age of three and a reliable diagnosis can be made by age two<sup>2</sup>. However, the average age of an ASD diagnosis in NJ is 4.4 years<sup>3</sup>. Intervention provided during the toddler and pre-school years is considered “early intervention.”

### *Early Intervention the System*

Early intervention the “system” is the public program that provides supports and services to eligible children, birth to age three, and their families under Part C of the Individuals with Disabilities Education Act (IDEA). State participation in the Federal Part C program is voluntary and currently all 50 states and territories have a Part C -Early Intervention System to focus on the needs of children with developmental delays under the age of 3.

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<sup>2</sup> Ibid.

<sup>3</sup> Centers for Disease Control and Prevention. Prevalence of Autism Spectrum Disorders Autism and Developmental Disabilities Monitoring Network, 14 sites, United States 2002. Surveillance Summaries, February 9, 2007. MMWR 2007; 56 (No. SS-1)

The NJ Department of Health and Senior Services is the lead agency for the Part C system, known as the NJEIS.

The mission of the NJEIS is to:

“Enhance the capacity of families to meet the developmental needs of children, birth to age three, who have delays or disabilities, by providing quality services and supports to families and their children”

Early intervention services and supports are determined through an Individualized Family Service Plan (IFSP) developed with the family, EI practitioners and other important persons in the child’s life. Because each plan is individualized to a particular child and family, no two plans will be the same, even for children with the same diagnosis or condition. All IFSPs are developed in accordance with the federal Part C requirements, N.J. A. C. 8:17 and the mission, policies, and procedures of the NJEIS.

The purpose of this guidance document is to assist service coordinators, provider agencies and families in designing quality intervention plans for children with autism spectrum disorders. For families, this guidance is intended to offer an understanding of the role the NJEIS and can have in assisting them with their child’s developmental needs.

Families with a child in need of “early intervention” (the concept) may choose to 1) access the supports and services provided through the NJEIS to meet all or some of their intervention needs, 2) access services and supports from other professionals outside of the NJEIS network at their own expense or 3) use some services from the NJEIS and some from other sources. Some families may have support needs that are beyond the scope of NJEIS.



Children with ASD have significant impairments in the areas of socialization, communication and behavior. The full diagnostic criteria is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (2000) published by the American Psychiatric Association. In the DSM-IV-TR, the umbrella term of Pervasive Developmental Disorder includes the classifications of Autistic Disorder, Asperger's Disorder, Rett's Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS).

“The manifestations of autism vary considerably across children and within an individual child over time. There is no single behavior that is always typical of autism and no behavior that would automatically exclude an individual child from a diagnosis of autism, even though there are strong and consistent commonalities, especially relative to social deficit”<sup>4</sup>

A child who enters the NJEIS with appropriate documentation of a diagnosis of an ASD is presumptively eligible for the system. The eligible child and family proceed through the initial assessment process in order to gather relevant information for developing the initial IFSP. This process includes family assessment, baseline developmental data gathering with the Battelle Developmental Inventory 2<sup>nd</sup> edition and a review of pertinent records related to the child's current health status and medical history. N.J. A.C. 8: 17- 8.8 states that when a child is diagnosed with ASD, the team conducting the initial assessment of that child must include at least one member with knowledge and experience in the area of ASD.

Children who do not have a documented diagnosis of ASD prior to referral are evaluated for eligibility according to NJEIS rules, policies and procedures. The initial evaluation/assessment by NJEIS determines system eligibility and gathers information relevant for the development of an IFSP. This includes identifying and understanding the family's concerns, resources and priorities for their child and family.

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<sup>4</sup> National Research Council (2001) *Educating Children with Autism*. Committee on Educational Interventions for Children with Autism. Catherine Lord and James P. McGee, eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

*NJEIS evaluators have a professional responsibility to inform a family if their evaluation raises concerns about signs and symptoms typically associated with ASD. Families will be encouraged to discuss the findings and concerns of the NJEIS team with their primary health care provider. NJEIS evaluation teams are not expected to diagnose children.*

**D**HSS has established seven “Core Beliefs” which are to guide IFSP teams as they develop and execute intervention plans for young children with ASD and their families. These Core Beliefs combine the philosophy of early intervention with the research in autism. The NJEIS Practice Model puts these core beliefs into action to achieve successful outcomes for children and families.

## The 7 Core Beliefs of NJEIS regarding children with ASD

1. Families are at the helm of their child’s plan and success.
2. Each child with ASD and family is unique, there is no one-size fits all model.
3. Autism is a complex disorder affecting all areas of functioning therefore collaborative efforts among professionals are needed to address the whole child and their needs.
4. Successful intervention for young children with ASD requires a significant amount of time be spent each day in engaging activities designed to address specific outcomes and goals.
5. Systematic instruction and careful planning are essential to effective intervention.
6. Intervention can be accomplished in various settings and by various people with support and proper planning.
7. Play is an essential part of children’s development and is the foundation for their learning.

(Adapted from the Early Start Denver Model, Rogers & Dawson, 2010)<sup>5</sup>

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<sup>5</sup>Dawson, S.J. & Dawson G. (2010). *Early Start Denver Model for Young Children with Autism*. New York, The Guildford Press

## Core Belief #1

**Families are at the helm of their child's plan and success.**

Family involvement is essential to good intervention. The research literature both in general early intervention and early intervention in autism consistently supports the active role of the family and other caregivers in the life of a child with special needs. In addition to working with the child, NJEIS practitioners actively integrate families into each hour of service to ensure that families learn to adapt their interactions, actions and routines in ways that enhance their family as well as the child's development.

### *NJEIS Practice Model:*

*Practitioners build the capacity of the parent to build the capacity of the child*

The goal of the NJEIS practitioners is to help parents/caregivers be and feel competent and be able to see the opportunities they have each day to enhance their child's skills and development. IFSP teams in the NJEIS should be careful not to design intervention plans that are practitioner-child driven and focused solely on instruction and intervention with the child. Intervention that is strictly child-focused weakens instead of strengthens parental competence and confidence.

Intervention that meets the child's needs and enhances the capacity of the family is directed to both the child and family. For those times when intervention strategies are practitioner-child focused and the family is not directly involved, practitioners must take steps to guarantee the family is able to freely observe those interactions.





## Core Belief # 2

**Each Child with ASD and their family is unique;  
there is no one-size-fits- all model.**

Because each family and child is unique the NJEIS does not recommend a standard frequency, intensity, level of service or set of strategies for children with (or without) ASD.

Research and evidence-based practice provides a foundation of information for what an individual child with ASD may need. The extensive literature in ASD has identified core areas of development typically in need of intervention supports and these elements are a part of ASD-specific curricula that NJEIS programs use. A curriculum helps shape the strategies chosen to achieve identified outcomes.

### *NJEIS Practice Model:*

*IFSPs are individualized  
based on family  
concerns, resources and  
priorities*

The unique characteristics of a particular child and the concerns, resources and priorities of the family provide the other vital and equally important pieces of information. For many families, the primary concern and priority is the delayed development of their child and the uncertainty and urgency that accompanies a diagnosis of ASD. For some families, concerns may also include additional issues such as: multiple children with special needs, financial constraints, language barriers, serious illness, unemployment, and/or mental health needs. Efforts to identify resources beyond the NJEIS that can assist the family in those areas are part of the IFSP process and the NJEIS mission. Resources, especially those in the local community (e.g. library story times, babysitters, and support groups) are an important part of the entire plan for the child and family. The core question for the IFSP team as they create an intervention plan is:

*“What does this child and this family need at this time?”*

Based on all relevant factors the IFSP team determines, in order, the:

1. Family concerns, priorities and resources;
2. The outcomes for the child and family based on those concerns;
3. The strategies that will be implemented to meet the outcomes; and
4. The type and amount of service that will be needed in order to meet those outcomes.

As the IFSP is implemented, the IFSP team is able to add individual child and family routines, objective measures of progress, and other data into decisions about frequency, intensity, strategy choices to further individualize the IFSP.

### Core Belief # 3

**Autism is a complex disorder affecting all areas of functioning therefore collaborative efforts among professionals are needed to address the whole child and their needs.**

Families of children with ASD often find supports and services from professional sources outside of the NJEIS. These resources may include specialty doctors, therapists, behavior consultants, play groups, childcare centers and advocates. The teams in NJEIS welcome the input of those professionals involved in the child's life and the IFSP should reflect those resources. The NJEIS team, through the family, works to ensure the overall plan for the child and family is coordinated to include those important resources. However, please note:

*Information, assessments and recommendations from physicians, neurologists and other professionals outside of the NJEIS are considered with all other information and clinical opinions. The fact that a physician may prescribe, order, recommend, or approve services does not, in itself, require the NJEIS to provide those services.*



*NJEIS Practice Model:*

*Professional collaboration is ongoing to ensure the needs of the whole child are addressed*

Within the NJEIS, professional collaboration is achieved through the teamwork of all the practitioners involved in the IFSP. Regular and on-going supervision of the IFSP and the implementation of the chosen strategies is the responsibility of the assigned NJEIS provider agency.

Supervision of practitioners and an IFSP includes:

- Observation of and feedback to of a practitioner in the home working with the child and family;
- Meeting with a practitioner(s) and/or family at the family home;
- Meeting with practitioners at the office, via phone or email;
- Review of progress notes, data and troubleshooting activities

It is considered best practice to review outcomes for children with ASD at *three month intervals*. It has been the experience of the NJEIS that the variations in progress typically seen in children with ASD and the complexity of some common strategy implementation necessitates the review and development of new or revised strategies within this time frame. Three month planning allows sufficient time for chosen strategies to be implemented and for objective measures of progress to be collected in order to maintain a proactive and flexible plan.

**Core Belief # 4**

**Successful intervention for young children with ASD requires a significant amount of time be spent each day in engaging activities designed to address specific outcomes and goals.**

Children with ASD have severe information processing deficits which can present on-going challenges to their learning in natural contexts. The developmental profiles of children with autism is qualitatively different from that of typically developing children and/or children with

other developmental delays and most families struggling with these differences will need significant support in learning how to engage their child effectively.

The child with ASD and his/her family will likely need multiple opportunities, in modified learning environments, to practice the skills needed to meet the outcomes identified on the IFSP. The NJEIS recognizes that children with ASD need direct professional contact/instruction to learn and meet their identified outcomes<sup>6</sup>.

*NJEIS Practice Model:*

*IFSP teams identify service needs with consideration for the daily activities, resources and priorities of the family*

The determination of the amount and type of direct services that will be needed to meet a child's outcomes is perhaps the most challenging at an initial IFSP meeting. There is no way to accurately predict an individual child and family's response to intervention or the frequency, intensity or type of service that will be needed. There is no "one-size-fits-all" intervention; however, research consistently informs that intensive intervention is needed.

However, what is *intensive* for one child and family may be very different for another. Therefore the IFSP team must use the NJEIS staff clinical knowledge, available information from evaluations and assessments (both within and outside of the system) and the family's routines to identify a starting point for services from the NJEIS.

The NJEIS promotes the practice of *gradual implementation* of services to ensure that what is provided is *appropriate and efficient*. In other words, the services should provide the child and family with the ability to meet the outcomes identified while efficiently utilizing all resources. A change in a child's routine, either with the initiation of services or a change to the frequency and intensity to on-going services requires an adjustment to new routines. In addition, the entire family must adjust their routines to include visits from practitioners, refine their skills as facilitators of their child's development and gather information relevant to autism, sources of support and available systems of service.

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<sup>6</sup> Ramey, C.T. & Ramey S.L. (1998). *Early Intervention and Early Experience*. American Psychologist, 53,2, 109-120

Gradual implementation allows for the team (including the family) to find the combination of services and supports that works for the child and the family and allows the team the time to document progress and provides a systematic method by which the appropriate frequency and intensity level for each individual child can be determined. Gradual implementation can occur over a few months or over a few weeks as the IFSP team gathers data that can appropriately justify the service/plan changes. Each hour of service must be considered within the context of the value it adds to or detracts from the achievement of the defined outcomes.

In addition to the time spent in planned intervention activities, the IFSP team should identify the daily routines and activities that in and of themselves provide opportunities for engaging children and teaching in natural contexts. Activities of a young child's daily routine such as dressing, feeding, diapering, bath-time and bed-time present additional opportunities for practice of targeted skills and outcomes.

Intervention plans should also provide opportunities for inclusion with typically developing peers in natural environments. Children with ASD should have the opportunity to be with their peers in typical settings and partake in community events each week as a way of increasing the time they are actively engaged. The IFSP team should identify local resources and assist the family in accessing those that meet their needs. Children should have opportunities for fully inclusive toddler or preschool settings, with appropriate supports, including community child care and recreational settings. This increases in priority as the child ages, attains skills, and prepares for transition from NJEIS. Transition planning for children exiting NJEIS at age three must consider the appropriateness of shifting some or all services from individual to group settings to prepare the child and family for preschool services.



## Core Belief # 5

### Systematic instruction and careful planning are essential to effective intervention.

Systematic instruction and careful planning are facilitated by the use of a curriculum designed for a specific age-group and areas that are in need of intervention. For children with ASD, the areas in need of intervention have been clearly identified in the research literature and by clinical consensus, and with that knowledge, autism-specific curricula have been developed. Appendix A outlines those areas typically in need of intervention in young children with ASD.

#### *NJEIS Practice Model:*

*IFSPs include well written outcomes, objectives measures of progress; use an autism-specific curriculum and evidence-based teaching strategies*

Beginning March 1, 2011, the DHSS will require that all Early Intervention Programs (EIPs) serving children with autism utilize an autism-specific curriculum to guide their planning and implementation of IFSPs. Although not all EIPs in the NJEIS will use the same curriculum, all curricula will be approved by DHSS based on a common standard (see Appendix B).

NJEIS supports the use of evidence-based strategies for all children that participate in system. Strategy choices should be selected based on the outcome to be achieved, developmental appropriateness and ease of implementation (practical and functional) for the family. The 2009 report *National Standard Project: Findings and Conclusions*<sup>7</sup> provides a comprehensive and up-to-date analysis about evidence-based practice for children with ASD and provides information on which strategies are appropriate for the young children served by the NJEIS. The report is one of many sources for IFSP teams to utilize when considering methods to achieve outcomes.

Finally, the IFSP team must determine and agree on the definition of “progress” and achievement of goals and outcomes and put in place plans to objectively measure the progress of the child and family. For example, if the outcome is for the child to communicate his wants and needs is the

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<sup>7</sup> National Autism Center (2009). *National Standards Project: Findings and Conclusions*. Massachusetts

measure of progress an increase in word approximations or only words understood by others?  
Do spoken words initiated by a prompt indicate progress or only those spontaneously used?  
The curricula designed for children with ASD typically include standard measures of progress as a part of the implementation plan. Collection of progress information is the responsibility of all members of the IFSP team and includes the family to the extent they are able.

### Core Belief # 6

**Intervention can be accomplished in various setting and by various people with support and proper planning.**

A core component of effective intervention for children with ASD is to ensure that emerging skills are generalized to multiple settings and multiple people.

#### *NJEIS Practice Model:*

*IFSP teams identify ways to support families and significant others in applying appropriate intervention strategies*

The parent training discussed and emphasized in Core Belief and Practice Model #1 is one way that generalization of skills is accomplished. But “family training” is not enough. Families and NJEIS staff must *believe in and support* intervention as a family affair. Siblings, grandparents, frequent caregivers, extended family and friends must also believe that they are capable of learning how to apply successful strategies that will help the child with ASD learn.

As a team, and over the course of intervention, the IFSP should identify, plan for and support increasing the skills of those directly involved with the child’s care on a daily basis.



### Core Belief # 7

**Play is an essential part of children's development and is the foundation for their learning.**

It is often said that “play is a child’s work” and NJEIS supports and values learning to play independently and with others as part of the intervention plan for all children. Play offers an ideal opportunity for parents to engage fully with their children and a child’s developmental trajectory is positively impacted when caregivers relate to children through play.<sup>8</sup>

Play is essential to development because it contributes to the cognitive, physical, social, and emotional well-being of children.<sup>9</sup> Play increases cognitive skills such as curiosity, problem solving and intentionality. Socio-emotionally, play can teach confidence, cooperation, reciprocity, sharing and appropriate communication. Physically, play increases fine motor and gross motor skills. These are skills that can last a lifetime and prepare a child for life after “early intervention”. Children’s play develops in stages and common stages of play are:

- **Onlooker Behavior:** Watching what other children are doing, but not joining in the play;
- **Solitary Play:** Playing alone without regard for others; being involved in independent activities like art or playing with blocks or other materials;
- **Parallel Activity:** Playing near others but not interacting, even when using the same play materials;
- **Associative Play:** Playing in small groups with no definite rules or assigned roles; and
- **Cooperative Play:** Deciding to work together to complete a building project or pretend play with assigned roles for all of the members of the group

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<sup>8</sup> Shonkoff, J.P. & Phillips, D.A. eds. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC, National Academy Press.

<sup>9</sup> Ginsburgh, K. (2007). *The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent-Child Bonds*. American Academy of Pediatrics. *Pediatrics*, 119,1, 182-191



*NJEIS Practice Model:*

*Play is included in IFSPs developed for children with ASD and their families*

Because of the social, emotional, behavioral and cognitive difficulties found in children with ASD it is expected that their play experiences would also be compromised.<sup>10</sup> Young children with ASD will often need instruction on *how* to play- how to initiate and sustain play, how to choose and participate in play activities that are not adult directed, and how to be socially appropriate with peers. NJEIS practitioners will model for families (including siblings) those strategies that encourage and develop play for the entire family unit. Children respond positively when caregivers are “silly” with them in play, so even the more serious, planned and structured learning activities should be constructed around play. When planning intervention outcomes and strategies, age appropriate play should be prioritized and not pushed aside in favor of skill development that focuses on pre-academics.



The NJEIS provides many different types of services to children and families in accordance with the federal law (IDEA). One of the most commonly used types of services provided by NJEIS is *Developmental Intervention*. This service is parallel to the federal definition of “Special Instruction” (section 303.12). This service can be provided by qualified personnel of varying backgrounds meeting NJEIS personnel standards. Developmental Intervention can include any and all of the teaching strategies and activities known to be effective and appropriate for young children and their families and those that have been developed for young children with a specific condition.

Many times families ask the NJEIS about receiving Applied Behavior Analysis or “ABA services”. The NJEIS does not provide a “service of ABA” or “ABA services” as a discrete service. The evidenced-based intervention strategies that are part of the science of ABA can be implemented

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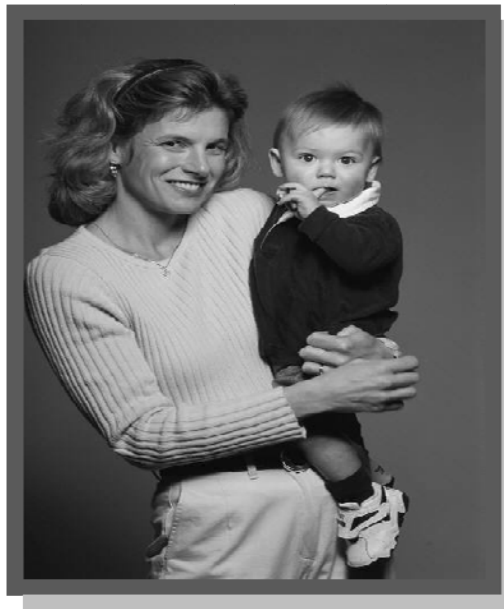
<sup>10</sup> Mastrangelo, S. (2009) *Harnessing the Power of Play: Opportunities for Children with Autism Spectrum Disorders*. Teaching Exceptional Children. 42, 1, 34-44

by the NJEIS through the service “Developmental Intervention”. The teaching strategies that are part of the Applied Behavioral Analysis framework and are appropriate for children under age three can be a part of the curriculum used by a provider agency and the strategies chosen to help a child and family make progress towards identified outcomes.



**I**n compiling the guidelines put forth in this document, the NJEIS has spent considerable time and attention to balancing the needs of all those who will be directly affected by them, including children and families, NJEIS personnel and the constituents of New Jersey.

These guidelines will be monitored in the coming months and years for their effectiveness in meeting the objective they were intended to meet: to assist service coordinators, providers and families in designing quality early intervention for children with autism spectrum disorders.



## Appendix A

*Commonly identified areas in need of intervention for infants and toddlers with ASD.*

**Self-regulation** - The ability to recover from stress

**Reciprocal Interactions** - Participation in reciprocal interactions, back and forth sharing between:

- Adult & Child
- Child & Child

**Attention** to task and acknowledgment of external world

**Eye contact** - Presenting and maintaining eye contact with multiple communication partners in multiple settings

**Joint attention** - using eye contact and gestures to show or direct the attention of other people. Critical for social development, language acquisition, cognitive development

**Attention shifting** - ability to shift attention from person to person, object to object

### Imitation

- Gross motor movements
- Fine motor movement
- Imitation in play
- Vocal imitation (both vocalizations and verbal imitation)

### Communication Skills

- **Receptive**- understanding gestures, common and meaningful vocabulary words, and following simple directions
- **Expressive**-use of gestures and vocalization/verbal speech with communicative intent, or alternatively use augmented communication (sign, picture representations) with communicative intent. Increase in complexity as progress indicates

### Play skills

- Solitary, parallel and associative play
- Turn taking
- Sustained attention to play for age appropriate lengths of time
- Ability to appropriately engage in play activities without constant adult supervision

### Socialization

### Choice-making

### Cognitive skills-

- Including early learning concepts
- Sorting, matching, classifying
- Understanding cause and effect
- Basic problem solving

## Appendix B

A “curriculum” is a complete program of planned learning opportunities that includes content, materials, resources and strategies needed for the learning process. Curricula typically consist of distinct components or modules and are flexible enough to meet an individual’s needs. A curricular program is coherent and whole and contains defined processes for evaluating the objectives.

Using a curriculum with children with autism in the NJEIS:

1. Increases intervention fidelity as persons implementing the program are trained in the goals, strategies and progress measures associated with that curriculum. The use of multiple methods sacrifices the time for extensive training in and understanding of each specific technique associated with a curricular base and most likely diminishes the efficacy of all the techniques used. If a practitioner does not understand the philosophy behind an intervention or cannot apply strategies with precision, it is highly unlikely that the method will be effective.
2. Meets federal and state regulations that require the use of evidence-based practice when possible. The literature on ASD and intervention techniques has produced significant evidence for the use of certain strategies and professional clinical consensus on the appropriateness of additional strategies.
3. Eliminates the use of “Eclectic” models which have little evidence of support. “Eclectic” models have been shown to be less-effective for children with ASD than programs structured by curriculum.



## Minimum Standard –

### Curricula for Children with ASD in NJEIS

DHSS will approve for use in the NJEIS a published curriculum package that has peer-reviewed research demonstrating effectiveness for children with autism ages 0-3.

OR

A comprehensive curriculum put into practice by the EIP, which meets the following minimal standards:

1. Intervention activities that are designed to address the core areas affected by autism identified by the National Research Council (2001). The activities are developmentally appropriate and implemented in systematic and planned manner.
  - a. **Functional, spontaneous communication** - including non-verbal communication.
  - b. **Social skills**- to enhance participation in family and community activities. Intervention activities target various settings.
  - c. **Cognitive development**- appropriate to developmental age including basic concepts, problem solving skills
  - d. **Play skills** -appropriate to developmental age and includes the ability to attend to the environment and other persons
  - e. **Fine and Gross motor skills**- used for age appropriate functional activities
  - f. **Inclusion of peers** - to the extent possible and in a variety of settings
  - g. Proactive strategies to address problem behavior when necessary.
2. At least 75% of the intervention strategies used to implement the curriculum have been identified as “established” National Standards Project (2009).
3. Has defined measures for determining progress and defined processes to troubleshoot when progress is limited.

*Selected intervention strategies “established” by  
The National Autism Center’s National Standards Project*

Choice making  
Cueing and prompting  
Prompt fading procedures  
Environmental modification of tasks  
Errorless learning,  
Incorporating echolalia  
Reinforcement strategies  
Discrete trial teaching  
Contriving motivational operations  
Functional communication training,  
Mand training  
Shaping  
Successive approximation,  
Task analysis  
Token economy  
Joint attention intervention  
Modeling  
Incidental teaching  
Peer-mediated social interactions  
Pivotal response Teaching

The complete report is available at  
[www.nationalautismcenter.org/about/national.php](http://www.nationalautismcenter.org/about/national.php)